NICE National Institute for Health and Care Excellence

NICE quality standard

Bladder cancer

Quality standard

Published: 17 December 2015

www.nice.org.uk/guidance/qs106

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This standard is based on NG2.

This standard should be read in conjunction with QS55, QS15, QS91 and QS124.

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Quality statement 1: Obtaining detrusor muscle during transurethral resection of bladder tumour

Quality statement

Adults who are having transurethral resection of bladder tumour (TURBT) have detrusor muscle obtained during the procedure.

Rationale

Obtaining detrusor muscle during TURBT is important for assessing the stage and type of bladder cancer, which can help to identify the most effective treatment.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that adults having TURBT have detrusor muscle obtained during the procedure.

Data source: Local data collection.

Process

Proportion of TURBT procedures during which detrusor muscle was obtained.

Numerator – the number in the denominator in which detrusor muscle was taken at the time of performing the TURBT.

Denominator – the number of TURBT procedures performed.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that systems are in place for adults who are having TURBT to have detrusor muscle obtained during the procedure.

Healthcare professionals ensure that adults who are having TURBT have detrusor muscle obtained during the procedure.

Commissioners ensure that they commission services that obtain detrusor muscle during TURBT procedures.

Adults who are having an operation to take tissue samples to check for bladder cancer (called transurethral resection of bladder tumour, or TURBT for short) have samples taken that include tissue from the muscle wall of their bladder. If cancer is found in their bladder, the type of treatment will depend on whether or not the cancer has grown into the muscle wall.

Source guidance

Bladder cancer: diagnosis and management. NICE guideline NG2 (2015), recommendation 1.2.4

Quality statement 2: Chemotherapy during transurethral resection of bladder tumour

Quality statement

Adults with suspected bladder cancer are offered a single dose of intravesical mitomycin C, given at the same time as the first transurethral resection of bladder tumour (TURBT).

Rationale

A single dose of intravesical mitomycin C given at the same time as the first TURBT has been found to reduce recurrence rates. Giving mitomycin C at the same time as the first TURBT is more convenient for the person having the TURBT and results in cost savings.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with suspected bladder cancer who are having a first TURBT are offered a single dose of intravesical mitomycin C, given at the same time as the TURBT.

Data source: Local data collection.

Process

Proportion of first TURBT procedures in which adults with suspected bladder cancer are

given a single dose of intravesical mitomycin C.

Numerator – the number in the denominator in which a single dose of intravesical mitomycin C is given.

Denominator – the number of first TURBTs performed for adults with suspected bladder cancer.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (for example secondary care services) ensure that systems are in place for adults having a first TURBT for suspected bladder cancer to be offered a single dose of intravesical mitomycin C, given at the same time as the TURBT.

Healthcare professionals offer adults having a first TURBT for suspected bladder cancer a single dose of intravesical mitomycin C, given at the same time as the TURBT.

Commissioners (NHS England) ensure that they commission services that offer adults having a first TURBT for suspected bladder cancer a single dose of intravesical mitomycin C, given at the same time as the TURBT.

Adults who are having a first operation to take tissue samples to check for bladder cancer (called transurethral resection of bladder tumour, or TURBT for short) are offered a single dose of an anticancer drug called mitomycin C, which is given when they have the operation. If cancer is found in their bladder, mitomycin C can reduce the chance of it coming back again in the future.

Source guidance

Bladder cancer: diagnosis and management. NICE guideline NG2 (2015), recommendation 1.2.7

Quality statement 3: Access to a clinical nurse specialist

Quality statement

Adults with bladder cancer have access to a designated clinical nurse specialist.

Rationale

Adults with bladder cancer who are supported by a clinical nurse specialist have a better experience of bladder cancer services than those who are not. The clinical nurse specialist can be involved in discussing treatment options and act as the person's key worker to address their information and care needs, including psychosocial support and referral to palliative care if needed. They can also discuss the effects of treatment on the person's body image and sexual health, and help them find relevant information.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that designated clinical nurse specialists are accessible to adults with bladder cancer.

Data source: Local data collection.

Process

Proportion of adults with bladder cancer who have a designated clinical nurse specialist.

Numerator – the number in the denominator who have a designated clinical nurse

specialist.

Denominator – the number of adults with bladder cancer in secondary care.

Data source: Local data collection.

Outcome

Satisfaction with support received from a clinical nurse specialist, reported by adults with bladder cancer.

Data source: Local data collection. The National Cancer Patient Experience Survey collects data on support from a clinical nurse specialist for adults with urological cancers.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that systems are in place for adults with bladder cancer to have access to a designated clinical nurse specialist.

Healthcare professionals offer adults with bladder cancer access to a designated clinical nurse specialist.

Commissioners ensure that they commission services that offer adults with bladder cancer access to a designated clinical nurse specialist.

Adults with bladder cancer are offered support from a clinical nurse specialist who has experience in caring for people with bladder cancer. The clinical nurse specialist can provide information about bladder cancer and the treatment options, and help them find information and other support they might need.

Source guidance

Bladder cancer: diagnosis and management. NICE guideline NG2 (2015), recommendations 1.1.1 and 1.1.2

Quality statement 4: Risk classification

Quality statement

Adults with newly diagnosed non-muscle-invasive bladder cancer have a risk classification of their cancer completed.

Rationale

Risk classification of non-muscle-invasive bladder cancer is used in multidisciplinary team discussions and in discussions with the person to help consider prognosis and decide treatment options.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with newly diagnosed non-muscle-invasive bladder cancer have a risk classification of their cancer completed.

Data source: Local data collection.

Process

Proportion of adults with newly diagnosed non-muscle-invasive bladder cancer who have a risk classification of their cancer completed.

Numerator – the number in the denominator who have a risk classification of their cancer completed.

Denominator – the number of adults with a new diagnosis of non-muscle-invasive bladder cancer.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that systems are in place for adults with newly diagnosed non-muscle-invasive bladder cancer to have a risk classification completed.

Healthcare professionals complete a risk classification for adults with newly diagnosed non-muscle-invasive bladder cancer.

Commissioners ensure that they commission services that complete a risk classification for adults with newly diagnosed non-muscle-invasive bladder cancer.

Adults with bladder cancer that has not grown into the muscle wall of the bladder have information about the likely future risk from their cancer, including the risk of it growing into the muscle wall, written in their notes when the cancer is first diagnosed. This information helps them and their doctors to decide the best treatment options.

Source guidance

Bladder cancer: diagnosis and management. NICE guideline NG2 (2015), recommendation 1.3.1

Definitions of terms used in this quality statement

Risk classification of non-muscle-invasive bladder cancer

Low risk

Urothelial cancer with any of:

- solitary pTaG1 with a diameter of less than 3 cm
- solitary pTaG2 (low grade) with a diameter of less than 3 cm
- any papillary urothelial neoplasm of low malignant potential.

Intermediate risk

Urothelial cancer that is not low risk or high risk, including:

- solitary pTaG1 with a diameter of more than 3 cm
- multifocal pTaG1
- solitary pTaG2 (low grade) with a diameter of more than 3 cm
- multifocal pTaG2 (low grade)
- pTaG2 (high grade)
- any pTaG2 (grade not further specified)
- any low-risk non-muscle-invasive bladder cancer recurring within 12 months of last tumour occurrence.

High risk

Urothelial cancer with any of:

- pTaG3
- pT1G2
- pT1G3
- pTis (Cis).

[NICE's guideline on bladder cancer, terms used in this guideline]

Quality statement 5: Discussing treatment options for high-risk non-muscle-invasive bladder cancer

Quality statement

Adults with high-risk non-muscle-invasive bladder cancer discuss intravesical Bacille Calmette-Guérin (BCG) and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist.

Rationale

Discussing the benefits and risks of intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist helps adults to make an informed choice about which treatment would best suit them. It ensures that they are aware of the possible outcomes and implications of both treatments, including likely effects on their quality of life, body image, and sexual and urinary functions.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with high-risk non-muscle-invasive bladder cancer discuss intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before a treatment option is agreed.

Data source: Local data collection.

Process

The proportion of adults with high-risk non-muscle-invasive bladder cancer who discuss intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before agreeing a treatment option.

Numerator – the number in the denominator who have a discussion about intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before agreeing a treatment option.

Denominator – the number of adults with newly diagnosed high-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

Outcome

Satisfaction with explanation of treatment options reported by adults with high-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that systems are in place for adults with high-risk non-muscle-invasive bladder cancer to discuss intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before agreeing a treatment option.

Healthcare professionals (urologists who perform both intravesical BCG and radical cystectomy, and clinical nurse specialists) discuss both procedures with adults who have high-risk non-muscle-invasive bladder cancer before agreeing a treatment option.

Commissioners ensure that they commission services in which a clinical nurse specialist and a urologist who performs both intravesical BCG and radical cystectomy discuss both of these procedures with adults who have high-risk non-muscle-invasive bladder before

agreeing a treatment option.

Adults with bladder cancer that has not grown into the muscle wall of the bladder, but has a high risk of doing so, have a discussion with a clinical nurse specialist and a specialist bladder cancer doctor about having treatment either with a vaccine called BCG, which can stop the cancer growing, or by having their bladder removed in an operation called cystectomy. Knowing the benefits and risks of these treatment options, including the likely effects on their future quality of life, will help them to choose the option that is best for them.

Source guidance

- Bladder cancer: diagnosis and management. NICE guideline NG2 (2015), recommendations 1.3.6 and 1.3.7
- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendation 1.5.14
- Expert opinion

Definitions of terms used in this quality statement

Discussion

Discussion should include:

- the type, stage and grade of the cancer, the presence of carcinoma in situ, the presence of variant pathology, prostatic urethral or bladder neck status and the number of tumours
- risk of progression to muscle invasion, metastases and death
- risk of understaging
- benefits of both treatments, including survival rates and the likelihood of further treatment
- risks of both treatments

- factors that affect outcomes (for example, comorbidities and life expectancy)
- impact on quality of life, body image, and sexual and urinary functions.

[NICE's guidelines on bladder cancer, recommendations 1.3.6 and 1.3.7 and patient experience in adult NHS services, recommendation 1.5.14; expert opinion]

Equality and diversity considerations

Radical cystectomy may not be suitable for people who have problems with manual dexterity or cognitive function, or people who have visual impairment.

Quality statement 6: Discussing treatment options for muscle-invasive urothelial bladder cancer

Quality statement

Adults with muscle-invasive urothelial bladder cancer discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

Rationale

Discussing the benefits and risks of neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist helps adults to make an informed choice about the treatments that would best suit them. It ensures that they are aware of the possible outcomes and implications of the treatments, including likely effects on their quality of life, body image, and sexual and urinary functions.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with muscle-invasive urothelial bladder cancer discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

Data source: Local data collection.

Process

The proportion of adults with muscle-invasive urothelial bladder cancer who discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist before agreeing a treatment option.

Numerator – the number in the denominator who have a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist before agreeing a treatment option.

Denominator – the number of adults with muscle-invasive urothelial bladder cancer.

Data source: Local data collection.

Outcome

Satisfaction with explanation of treatment options reported by adults with muscle-invasive urothelial bladder cancer.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that systems are in place for adults with muscle-invasive urothelial bladder cancer to discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist before agreeing a treatment option.

Healthcare professionals (urologists who perform radical cystectomy, clinical oncologists and clinical nurse specialists) discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with adults who have muscle-invasive urothelial bladder cancer before agreeing a treatment option.

Commissioners (NHS England) ensure that they commission services in which a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with adults who have muscle-invasive urothelial bladder cancer before agreeing a treatment option.

Adults with bladder cancer that has grown into the muscle wall of the bladder have a discussion with a clinical nurse specialist and specialist bladder cancer doctors about either having their bladder removed (cystectomy) or having radiotherapy (high-energy rays that destroy cancer cells). They also discuss having chemotherapy (treatment with anticancer drugs) before having either of these treatments. Knowing the benefits and risks of these treatment options, including the likely effects on their future quality of life, will help them to choose the option that is best for them.

Source guidance

Bladder cancer: diagnosis and management. NICE guideline NG2 (2015), recommendations 1.5.2 to 1.5.6

Definitions of terms used in this quality statement

Discussion

Adults with newly diagnosed muscle-invasive urothelial bladder cancer for whom cisplatin-based chemotherapy is suitable should be offered neoadjuvant chemotherapy using a cisplatin combination regimen before radical cystectomy or radical radiotherapy. They should have an opportunity to discuss the risks and benefits with an oncologist who treats bladder cancer.

Adults with muscle-invasive urothelial bladder cancer for whom radical therapy is suitable should be offered a choice of radical cystectomy or radiotherapy with a radiosensitiser, and have their choice of treatment based on a discussion with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

The discussion includes:

- the prognosis with or without treatment

- the limited evidence about whether surgery or radiotherapy with a radiosensitiser is the most effective cancer treatment
- the benefits and risks of surgery and radiotherapy with a radiosensitiser, including the impact on sexual and bowel functions and the risk of death as a result of the treatment.

[NICE's guideline on bladder cancer, recommendations 1.5.2 to 1.5.6]

Equality and diversity considerations

Radical cystectomy may not be suitable for people who have problems with manual dexterity or cognitive function, or people who have visual impairment.

Quality statement 7: Discharge to primary care

Quality statement

Adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial transurethral resection of bladder tumour (TURBT) are discharged to primary care.

Rationale

Discharging adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months to primary care reduces the need for follow-up cystoscopies in secondary care. It is important that the discharge is discussed with the patient beforehand, and that written information about the patient's care is sent to the GP who will be taking over their care when they are discharged.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements for adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT to be discharged to primary care.

Data source: Local data collection.

Process

Proportion of adults who have had low-risk non-muscle-invasive bladder cancer and who

have no recurrence of the bladder cancer within 12 months of their initial TURBT who are discharged to primary care.

Numerator – the number in the denominator who are discharged to primary care.

Denominator – the number of adults who have had low-risk non-muscle-invasive bladder cancer who have no recurrence of the bladder cancer within 12 months of their initial TURBT.

Data source: Local data collection.

Outcome

Satisfaction with discharge to primary care reported by adults who have had low-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that systems are in place for adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT to be discharged to primary care.

Healthcare professionals discharge to primary care adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT.

Commissioners ensure that they commission services that discharge to primary care adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT. Commissioners work with providers in primary and secondary care to ensure that there is good communication between primary care, secondary care and the person who is being discharged.

Adults who have had bladder cancer removed in an operation called transurethral resection of bladder tumour, or TURBT for short, are discharged back to their GP after 1 year if there are no further signs of cancer, the cancer had not spread into the muscle wall of the bladder, and it was a type of cancer with a low risk of spreading or coming back in the future.

Source guidance

Bladder cancer: diagnosis and management. NICE guideline NG2 (2015), recommendation 1.4.5

Update information

Minor changes since publication

September 2025: Source guidance references were updated to align with changes to NICE's guideline on bladder cancer.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Good communication between healthcare professionals and

adults with bladder cancer is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with bladder cancer should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN: 978-1-4731-1613-9

Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Pathologists
- Royal College of Nursing (RCN)